MDR Tracking Number: M5-04-1159-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on December 23, 2003.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The stimulation was found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 10/14/03 through 10/20/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 1st day of March 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

February 26, 2004

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IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___was injured on the job on ___ while lifting and moving scaffolding weighing about 100 pounds. He felt a sudden pop and pain in his low back, but continued to work. His symptoms did not resolve He sought care from ___, a chiropractor, on 2/11/03 for complaints of constant lumbar pain and bilateral radicular pain down his legs to his calves He also reported numbness and tingling down to his feet bilaterally, and he reported that bending, lifting and sudden movements were painful.

___ removed him from work on 2/17/03, stating that continued work was aggravating his condition and depriving him of the opportunity to recover from his injuries. ___ ordered an MRI of the lumbar spine on 3/7/03, and upon reviewing it on 3/24/03 he referred ___to an orthopedic physician.

___ ceased chiropractic care on 3/26/03. On 8/6/03 ___underwent costo-transversectomy, laminectomy and facet surgery with ___ for his injury. On 10/7/03, ___ referred ___back to ___ for postoperative care. The following six weeks of postoperative care with ___ consisted of stimulation, massage, ultrasound and exercises On 10/29/03, ___, a physician chosen by ___, saw ___. ___ determined that the care rendered was appropriate and related to the work-related injury. He also determined that this patient was able to return to work with restrictions.

DISPUTED SERVICES

Under dispute is the medical necessity of stimulation provided to this patient from 10/14/03 through 10/20/03.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

The insurance carrier denied payment to ___, claiming that the treatment/service provided exceeded medically accepted utilization review criteria and/or reimbursement guidelines established for severity of injury, intensity of service and appropriateness of care. The TWCC adoption of Medicare guidelines is mandated in labor code 413.011 (a) HB2600. In Vorster v. Bowen (709 F. Supp 734 D. California 1989) the courts significantly limited the ability of Medicare to deny claims and reconsideration solely based upon utilization review criteria. When documentation is submitted with the claim, then screening criteria may not be used alone to deny the claim. It must be reviewed. A peer did not review ___ claim.

The reviewer finds that the care provided by ___ was reasonable and not excessive. He also finds that the care provided to ___falls within the parameters set forth in the Texas Guidelines for Chiropracatic Quality Assurance and Practice Parameters, a TCA Publication, 1994.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy

As an officer of ___, Inc, dba ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding this finding by US Postal Service to the TWCC.

Sincerely,